BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA.

In the Matter of the Accusation Against:	)	
WILLIAM H. JOHNSON, M.D.	)	File No: 19-2003-142002
Physician's and Surgeon's Certificate #G 46239	)	
Respondent.	)	

DECISION AND ORDER

The attached Stipulated Settlement and Disciplinary Order is hereby accepted and adopted as the Decision and Order by the Division of Medical Quality of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on September 19, 2005

IT IS SO ORDERED August 18, 2005

MEDICAL BOARD OF CALIFORNIA

Steve Alexander
Chair, Panel A
Division of Medical Quality

BILL LOCKYER, Attorney General
of the State of California
JOSE R. GUERRERO, Supervising
Deputy Attorney General
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Attorneys for Complainant

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: WILLIAM JOHNSON, M.D. 2260 Gladstone Drive, Suite 2 Pittsburg, CA 94565 Physician's and Surgeon's Certificate No. G46239 Respondent.	Case No. 19 2003 142002 OAH No. 2005 040006 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. David T. Thornton (Complainant) is the Executive Director of the Medical Board of California. He brought this action solely in his official capacity and is represented in this matter by Bill Lockyer, Attorney General of the State of California, by Lynne K. Dombrowski, Deputy Attorney General.

2. William H. Johnson, Jr., M.D. (Respondent) is representing himself in this proceeding and has chosen not to exercise his right to be represented by counsel.

3. On or about September 29, 1981, the Medical Board of California issued Physician's and Surgeon's Certificate No. G46239 to William H. Johnson, Jr. M.D. (Respondent).

The Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 19 2003 142002 and will expire on February 28, 2007, unless renewed.

JURISDICTION

4. Accusation No. 19 2003 142002 was filed before the Division of Medical Quality (Division) for the Medical Board of California, Department of Consumer Affairs, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on August 12, 2004. Respondent filed his Notice of Defense contesting the Accusation. A copy of Accusation No. 19 2003 142002 is attached as Exhibit A and incorporated herein by reference.

5. Respondent's Physician's and Surgeon's Certificate is currently on probation for a prior disciplinary action. Effective June 1, 2000, in a stipulated settlement of a prior disciplinary action entitled *In the Matter of the Accusation Against William Johnson, M.D.* before the Medical Board of California, Case Number 12 1997 71148, Respondent's license was revoked and said revocation stayed with a probation of five years with special terms and conditions. That decision is final and said probation is scheduled to end on June 1, 2005. A copy of the Decision in Case No. 12 1997 71148 is attached as Exhibit B and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, and understands the charges and allegations in Accusation No. 19 2003 142002. Respondent has also carefully read, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to be represented by counsel at his own expense; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

8. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 19 2003 142002, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis for the charges in the Accusation, and that Respondent hereby gives up his right to contest those charges.

11. Respondent agrees that his Physician's and Surgeon's Certificate is subject to discipline and he agrees to be bound by the Division's imposition of discipline as set forth in the Disciplinary Order below.

12. The parties stipulate that the discipline below does not arise from any type of surgical service or invasive procedure and that, therefore, section 14124.12 of the Welfare and Institutions Code is not applicable to this matter.

CONTINGENCY

13. This stipulation shall be subject to approval by the Division of Medical Quality. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Division regarding this stipulation and settlement, without notice to or participation by Respondent. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Division considers and acts upon it. If the Division fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Division shall not be disqualified from further action by having considered this matter.

14. The parties understand and agree that facsimile copies of this Stipulated Settlement and Disciplinary Order, including facsimile signatures thereto, shall have the same force and effect as the originals.

15. In consideration of the foregoing admissions and stipulations, the parties agree that the Division may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that the probation imposed and currently in effect on Physician's and Surgeon's Certificate No. G46239 issued to Respondent William H. Johnson, M.D. is hereby extended until December 31, 2005. The following terms and conditions of probation shall be in effect:

1. MEDICAL RECORD KEEPING COURSE Within 60 calendar days of the effective date of this decision, respondent shall enroll in a course in medical record keeping, at respondent's expense, approved in advance by the Division or its designee. Failure to successfully complete the course 45 days prior to the completion of probation is a violation of probation.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Division or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Division or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Division or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

2. MONITORING OF PRACTICE For the duration of the probation, respondent shall continue with a Division-approved practice monitor who is a physician and surgeon with a valid license in good standing and who is preferably certified by the American Board of Medical Specialties (ABMS). The monitor shall have no prior or current business or

personal relationship with respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Division, including, but not limited to, any form of bartering, shall be in respondent's field of practice, and must agree to serve as respondent's monitor. Respondent shall pay all monitoring costs.

The Division or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours, and shall retain the records for the entire term of probation.

The monitor shall submit a quarterly written report to the Division or its designee which includes an evaluation of respondent's performance, indicating whether respondent's practices are within the standards of practice of medicine and whether respondent is practicing medicine safely.

It shall be the sole responsibility of respondent to ensure that the monitor submits the quarterly written reports to the Division or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Division or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If respondent fails to obtain approval of a replacement monitor within 60 days of the resignation or unavailability of the monitor, respondent shall be

suspended from the practice of medicine until a replacement monitor is approved and prepared to assume immediate monitoring responsibility. Respondent shall cease the practice of medicine within 3 calendar days after being so notified by the Division or designee.

Failure to maintain all records, or to make all appropriate records available for immediate inspection and copying on the premises, or to comply with this condition as outlined above is a violation of probation.

3. CONTROLLED DRUGS - MAINTAIN RECORD Respondent shall maintain a record of all controlled substances prescribed, dispensed or administered by respondent during probation, showing all the following: 1) the name and address of the patient, 2) the date, 3) the character and quantity of controlled substances involved, and 4) the indications and diagnoses for which the controlled substance was furnished. Respondent shall keep these records in a separate file or ledger, in chronological order, and shall make them available for inspection and copying by the Division or its designee, upon request.

4. OBEY ALL LAWS Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California, and remain in full compliance with any court ordered criminal probation, payments and other orders.

5. QUARTERLY DECLARATIONS Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Division, stating whether there has been compliance with all the conditions of probation. Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

6. PROBATION UNIT COMPLIANCE Respondent shall comply with the Division's probation unit. Respondent shall, at all times, keep the Division informed of respondent's business and residence addresses. Changes of such addresses shall be immediately communicated in writing to the Division or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

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Respondent shall not engage in the practice of medicine in respondent's place of residence. Respondent shall maintain a current and renewed California physician's and surgeon's license.

Respondent shall immediately inform the Division, or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than 30 calendar days.

7. INTERVIEW WITH THE DIVISION, OR ITS DESIGNEE Respondent shall be available in person for interviews either at respondent's place of business or at the probation unit office, with the Division or its designee, upon request at various intervals, and either with or without prior notice throughout the term of probation.

8. RESIDING OR PRACTICING OUT-OF-STATE In the event respondent should leave the State of California to reside or to practice, respondent shall notify the Division or its designee in writing 30 calendar days prior to the dates of departure and return. Non-practice is defined as any period of time exceeding 30 calendar days in which respondent is not engaging in any activities defined in Sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program outside the State of California which has been approved by the Division or its designee shall be considered as time spent in the practice of medicine within the State. A Board-ordered suspension of practice shall not be considered as a period of non-practice. Periods of temporary or permanent residence or practice outside California will not apply to the reduction of the probationary term. Periods of temporary or permanent residence or practice outside California will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws and Probation Unit Compliance.

Respondent's license shall be automatically cancelled if respondent's periods of temporary or permanent residence or practice outside California total two years. However, respondent's license shall not be cancelled as long as respondent is residing and practicing medicine in another state of the United States and is on active probation with the medical

licensing authority of that state, in which case the two year period shall begin on the date probation is completed or terminated in that state.

9. FAILURE TO PRACTICE MEDICINE - CALIFORNIA RESIDENT

In the event respondent resides in the State of California and for any reason respondent stops practicing medicine in California, respondent shall notify the Division or its designee in writing within 30 calendar days prior to the dates of non-practice and return to practice. Any period of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary term and does not relieve respondent of the responsibility to comply with the terms and conditions of probation. Non-practice is defined as any period of time exceeding 30 calendar days in which respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program which has been approved by the Division or its designee shall be considered time spent in the practice of medicine. For purposes of this condition, non-practice due to a Board-ordered suspension or in compliance with any other condition of probation, shall not be considered a period of non-practice.

Respondent's license shall be automatically cancelled if respondent resides in California and for a total of two years, fails to engage in California in any of the activities described in Business and Professions Code sections 2051 and 2052.

10. COMPLETION OF PROBATION Respondent shall comply with all financial obligations (e.g., probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, respondent's certificate shall be fully restored.

11. VIOLATION OF PROBATION Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Division, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, Petition to Revoke Probation, or an Interim Suspension Order is filed against respondent during probation,

the Division shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

12. LICENSE SURRENDER Following the effective date of this Decision, if respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request the voluntary surrender of respondent's license. The Division reserves the right to evaluate respondent's request and to exercise its discretion whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Division or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation and the surrender of respondent's license shall be deemed disciplinary action. If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

13. PROBATION MONITORING COSTS Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Division, which are currently set at $3,173, but may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Division or its designee no later than January 31 of each calendar year. Failure to pay costs within 30 calendar days of the due date is a violation of probation.

ACCEPTANCE

I have carefully read the Stipulated Settlement and Disciplinary Order. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Division of Medical Quality, Medical Board of California.

DATED: 7/27/05

WILLIAM JOHNSON, M.D.
Respondent

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Division of Medical Quality, Medical Board of California of the Department of Consumer Affairs.

DATED: 8/5/2005.

BILL LOCKYER, Attorney General
of the State of California

Lynne K. Dombrowski

LYNNE K. DOMBROWSKI
Deputy Attorney General

Attorneys for Complainant

Exhibit A

Accusation No. 19 2003 142002

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Attorneys for Complainant

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: WILLIAM JOHNSON, M.D. 2260 Gladstone Drive, Suite 2 Pittsburg, CA 94565 Physician's and Surgeon's Certificate No. G46239 Respondent.	Case No. 19 2003 142002 **ACCUSATION**

Complainant alleges:

PARTIES

1. David T. Thornton (Complainant) brings this Accusation solely in his official capacity as the Interim Executive Director of the Medical Board of California, Department of Consumer Affairs.

2. On or about September 29, 1981, the Medical Board of California issued Physician's and Surgeon's Certificate Number G46239 to William Johnson, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on February 28, 2005, unless renewed.

JURISDICTION

3. This Accusation is brought before the Division of Medical Quality (Division) for the Medical Board of California, Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Division deems proper.

5. Section 2234 of the Code states:

"The Division of Medical Quality shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following: . . .

"(b) Gross negligence."

6. Section 125.3 of the Code provides, in pertinent part, that the Division may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

7. Section 14124.12 of the Welfare and Institutions Code states, in pertinent part:

"(a) Upon receipt of written notice from the Medical Board of California. . . that a licensee's license has been placed on probation as a result of a disciplinary action, the department may not reimburse any Medi-Cal claim for the type of surgical service or invasive procedure that gave rise to the probation that was performed by the licensee on or after the effective date of probation and until the termination of all probationary terms and conditions or until the probationary period has ended, whichever occurs first. This section shall apply except in any case in which the relevant licensing board determines that compelling circumstances warrant the continued reimbursement during the

probationary period of any Medi-Cal claim, including any claim for dental services, as so described. In such a case, the department shall continue to reimburse the licensee for all procedures, except for those invasive or surgical procedures for which the licensee was placed on probation."

8. On or about January 8, 2003, the Medical Board received a Report of Settlement, Judgment or Arbitration Award which indicated that a payment of $410,000 had been paid on behalf of respondent to settle Alameda County Superior Court civil case no. 825781-9, filed on April 27, 2000, on behalf of plaintiff Robert T.. Pursuant to this notification, the Medical Board began its own investigation.

CAUSE FOR DISCIPLINE

(Unprofessional Conduct/Gross Negligence)

9. Respondent is subject to disciplinary action under section 2234 of the Business and Professions Code in that he is guilty of unprofessional conduct through gross negligence with regard to his treatment and failure to properly examine and treat patient Robert T. on and/or prior to March 9, 1999, under the circumstances as presented in more detail below.

10. On or about February 18, 1999, patient Robert T., a 67-year-old man, saw respondent, who had been his primary physician since sometime in 1989. Patient Robert T. presented with an eye and left-face contusion, his eyelid was swollen, there was red sclera, and the patient complained of headache and pain in swallowing. The patient apparently had difficulty opening his jaw. Respondent noted that the patient's pupils were equal and reactive to light. Respondent's written assessment was: "contusion/concussion, ?jaw fracture." Although patient Robert T. told respondent that the injuries were the result of an accident, respondent believed that the patient was being evasive and suspected that the patient had been beaten. Respondent prescribed Tylenol #3 for the patient's pain.

11. Respondent has no record that he discussed, at the February 18 visit, whether the patient had a loss of consciousness and that he checked the patient's reflexes and observed his coordination. Respondent also did not document that patient Robert T. had received treatment in a hospital emergency room for his injuries, including sutures to his eyelid.

12. On or about March 8, 1999, less than three weeks later, patient Robert T. returned to see respondent with the complaint that he was dizzy, that he had fallen during the day, and that his jaw was painful. Respondent noted that the patient's status was "post concussion." Respondent made the following written observations in the patient's chart: "pupils equal, reactive to light. No injection, lid swollen, Dizziness/headache secondary to the first. Further exam: Chest clear, gait normal. No fever, chills, sweats. Gastritis, constipation." Respondent's plan was to continue with Tylenol 3 and with Motrin and to prescribe Prevacid 3 for the patient's gastritis.

13. On or about the morning of March 9, 2000, patient Robert T. was found at home in a comatose state with foaming at the mouth. Patient Robert T. arrived at the hospital in a total coma and was diagnosed with bilateral subdural hematomas which were "bifronto-temporal and appeared to have both old and new components." Robert T. remained hospitalized for approximately three weeks and was then transferred to a nursing facility where he remained for about one year.

14. Patient Robert T. died in or about March 2001, without ever awakening from his coma.

15. Respondent is subject to disciplinary action as described herein pursuant to section 2234, subdivision (b) of the Code in that he is guilty of unprofessional conduct and has demonstrated gross negligence as more particularly alleged below:

(1) Respondent failed to conduct and document a complete history and physical examination on patient Robert T., including but not limited to: failing to obtain a history of loss of consciousness for a head trauma patient, failing to verify and clarify the nature of the patient's recent fall, failing to indicate in the history whether drugs or alcohol were involved, failing to document whether the patient's reported symptoms changed between visits, failing to do a complete neurological assessment;

(2) Respondent, in making an assessment of concussion and possible jaw fracture, failed to properly treat and/or document treatment and follow-up recommendations, including but not limited to: failing to perform and document a complete neurological

assessment, and failing to provide information instructing the patient on symptoms or signs necessitating a prompt re-evaluation;

(3) Respondent failed to thoroughly evaluate the patient's head injury, including but not limited to: failing to obtain the patient's pertinent past medical records, copies of records, x-rays, and treatment recommendations given to the patient by emergency room physicians and failing to perform a complete neurological assessment; and/or

(4) Respondent failed to report a suspected battery.

DISCIPLINE CONSIDERATIONS

16. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that effective June 1, 2000, in a stipulated settlement of a prior disciplinary action entitled *In the Matter of the Accusation Against William Johnson, M.D.* before the Medical Board of California, Case Number 12 1997 71148, Respondent's license was revoked and said revocation stayed with a probation of five years with special terms and conditions. That decision is final and is incorporated by reference as if fully set forth.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Division of Medical Quality issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number G46239, issued to William Johnson, M.D.;

2. Revoking, suspending or denying approval of William Johnson, M.D.'s authority to supervise physician's assistants, pursuant to section 3527 of the Code;

3. Ordering William Johnson, M.D. to pay the Division of Medical Quality the reasonable costs of the investigation and enforcement of this case, and, if placed on probation, the costs of probation monitoring;

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4. Taking such other and further action as deemed necessary and proper.

DATED: August 12, 2004

DAVID T. THORNTON
Interim Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

03573160-SF2004400492

Exhibit B

Decision, Case No. 12 1997 71148

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
WILLIAM H. JOHNSON, JR., M.D. Certificate No. G-46239	)	No: 12-1997-71148
Respondent	)	

DECISION

The attached Stipulation for Settlement and Decision is hereby adopted by the Division of Medical Quality as its Decision in the above-entitled matter.

This Decision shall become effective at 5:00 p.m. on June 1, 2000.

IT IS SO ORDERED May 2, 2000.

By: _____
ANABEL ANDERSON IMBERT, M.D.
Panel A
Division of Medical Quality

BILL LOCKYER, Attorney General
of the State of California
VIVIEN HARA HERSH, Supervising
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Attorneys for Complainant

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	Case No. 12-97-71148 OAH No. N1999 080082
WILLIAM H. JOHNSON, JR., M.D. 2260 Gladstone Drive, Suite 2 Pittsburg, CA 94565 Physician's and Surgeon's Certificate No. G46239, Respondent.	**STIPULATION FOR SETTLEMENT AND DECISION**

In the interest of a prompt and speedy settlement of this matter, consistent with the public interest and the responsibility of the Division of Medical Quality, Medical Board of California, Department of Consumer Affairs ("Division") the parties hereby agree to the following Stipulation for Settlement and Decision which will be submitted to the Division for its approval and adoption as the final disposition of the Accusation.

PARTIES

1. Complainant Ron Joseph is the Executive Director of the Medical Board of California who brought this action solely in his official capacity and is represented in this

matter by Bill Lockyer, Attorney General of the State of California, by Lynne K. Dombrowski, Deputy Attorney General.

2. Respondent William H. Johnson Jr., M.D. ("respondent")is represented by his attorneys Brock Phillips, Esq. of Sturgeon, Keller, Phillips, Gee & O'Leary, 388 Market Street, Suite 670, San Francisco, CA 94111. Respondent has had the opportunity to and has in fact reviewed the terms and conditions of this stipulation with his attorneys and enters into this stipulation with the advice of his attorneys mentioned herein.

3. At all times relevant herein, respondent has been licensed by the Medical Board of California under physician's and surgeon's certificate No. G46239.

JURISDICTION

4. Accusation No. 12-97-71148 was filed before the Division and is currently pending against respondent. The Accusation, together with all other statutorily required documents, was duly served on the respondent on April 12, 1999, and respondent timely filed a Notice of Defense contesting the Accusation. A copy of Accusation No. 12-97-71148 is attached hereto as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

5. Respondent understands that the charges and allegations in the Accusation, if proven at a hearing, constitute cause for imposing discipline upon his physician's and surgeon's certificate No. G46239. Respondent is fully aware of his legal rights and that, but for this Stipulation, he would be entitled: 1) to a hearing on the charges and allegations in the Accusation; 2) to be represented by counsel, at his own expense, in all proceedings in this matter; 3) to confront and cross-examine the witnesses against him; 4) to present evidence on his own behalf and to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; 5) to reconsideration and appeal of an adverse decision; and 6) to all other rights accorded pursuant to the California Administrative Procedure Act and other applicable laws.

6. In order to avoid the expense and uncertainty of a hearing, respondent freely and voluntarily waives each and every one of these rights set forth above. Respondent admits that the Board has jurisdiction to enter into this stipulation and to impose discipline upon his physician's and surgeon's certificate pursuant to Business and Professions Code sections 2234, 2234(c) (repeated negligent acts) and 2266 (inadequate record keeping).

7. Respondent's license history and status as set forth in paragraph 2 of the Accusation are true and correct. Respondent's address of record is correct as set forth in the caption of this stipulation.

8. The admissions made by respondent herein are only for the purposes of this proceeding, or any other proceedings in which the Division of Medical Quality, Medical Board of California or other professional licensing agency is involved, and shall not be deemed to be admissions for any purpose in any other administrative, civil or criminal proceedings.

9. For the purpose of resolving Accusation No. 12 97 71148 without further expense, complainant hereby withdraws the following alleged causes for discipline contained in the Accusation attached hereto as Exhibit A: the third, eleventh and nineteenth causes of discipline (dishonest/corrupt acts re: medical records); the fifth, thirteenth, and twenty-first causes for discipline (prescribing to an addict/habitual user); and the eighth, sixteenth, and twenty-fourth causes for discipline (prescribing without a legitimate purpose).

10. The parties stipulate that the discipline below does not arise from any type of surgical service or invasive procedure and that, therefore, section 14124.12 of the Welfare and Institutions Code is not applicable to this matter.

CONTINGENCY

11. This stipulation shall be subject to the approval of the Division. Respondent understands and agrees that Board staff and counsel for complainant may communicate directly with the Division regarding this stipulation and settlement, without notice to or participation by respondent. If the Division fails to adopt this stipulation as its Order, the stipulation shall be of no force or effect, it shall be inadmissible in any legal action

between the parties, and the Division shall not be disqualified from further action in this matter by virtue of its consideration of this stipulation.

12. In consideration of the foregoing admissions and stipulations, the parties agree that the Division shall, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that physician's and surgeon's certificate No. G46239 issued to William H. Johnson, Jr., M.D. is revoked. However, the revocation is stayed and respondent is placed on probation for five (5) years on the following terms and conditions. Within 15 days after the effective date of this decision the respondent shall provide the Division, or its designee, proof of service that respondent has served a true copy of this decision on the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent or where respondent is employed to practice medicine and on the Chief Executive Officer at every insurance carrier where malpractice insurance coverage is extended to respondent.

1. PRESCRIBING PRACTICES COURSE Within ninety (90) days of the effective date of this decision, respondent shall enroll in a course in Prescribing Practices, approved in advance by the Division or its designee, and shall successfully complete the course during the first year of probation.

2. CONTROLLED DRUGS - MAINTAIN RECORD Respondent shall maintain a record of all controlled substances prescribed, dispensed or administered by respondent during probation, showing all the following: 1) the name and address of the patient, 2) the date, 3) the character and quantity of controlled substances involved, and 4) the indications and diagnoses for which the controlled substance was furnished.

Respondent shall keep these records in a separate file or ledger, in chronological order, and shall make them available for inspection and copying by the Division or its designee, upon request.

3. MONITORING Within thirty (30) days of the effective date of this decision, respondent shall submit to the Division or its designee for its prior approval a plan of practice in which respondent's practice shall be monitored by another physician in respondent's field of practice, who shall meet with respondent on a monthly basis and who shall provide periodic quarterly reports to the Division or its designee.

Upon receipt of a written request by respondent, the Division or its designee agrees to re-evaluate the requirement of a physician monitor after the first year of probation.

If the monitor resigns or is no longer available, respondent shall, within fifteen (15) days, move to have a new monitor appointed, through nomination by respondent and approval by the Division or its designee.

4. OBEY ALL LAWS Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California, and remain in full compliance with any court ordered criminal probation, payments and other orders.

5. QUARTERLY REPORTS Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Division, stating whether there has been compliance with all the conditions of probation.

6. PROBATION SURVEILLANCE PROGRAM COMPLIANCE Respondent shall comply with the Division's probation surveillance program. Respondent shall, at all times, keep the Division informed of his addresses of business and residence which shall both serve as addresses of record. Changes of such addresses shall be immediately communicated in writing to the Division. Under no circumstances shall a post office box serve as an address of record.

Respondent shall also immediately inform the Division, in writing, of any travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) days.

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7. INTERVIEW WITH THE DIVISION, ITS DESIGNEE OR ITS DESIGNATED PHYSICIAN(S) Respondent shall appear in person for interviews with the Division, its designee or its designated physician(s) upon request at various intervals and with reasonable notice.

8. TOLLING FOR OUT-OF-STATE PRACTICE, RESIDENCE OR IN-STATE NON-PRACTICE In the event respondent should leave California to reside or to practice outside the State or for any reason should respondent stop practicing medicine in California, respondent shall notify the Division or its designee in writing within ten (10) days of the dates of departure and return or the dates of non-practice within California. Non-practice is defined as any period of time exceeding thirty days in which respondent is not engaging in the practice of medicine as defined in Sections 2051 and 2052 of the Business and Professions Code. All time spent in an intensive training program approved by the Division or its designee shall be considered as time spent in the practice of medicine. Periods of temporary or permanent residence or practice outside California or of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary period.

9. COMPLETION OF PROBATION Upon successful completion of probation, respondent's certificate shall be fully restored.

10. VIOLATION OF PROBATION If respondent violates probation in any respect, the Division, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an accusation or petition to revoke probation is filed against respondent during probation, the Division shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

11. COST RECOVERY The respondent is hereby ordered to reimburse the Division for its investigative and prosecution costs in the amount of $7,000 which is to be paid in four installments of $1,750 each, with the first payment of $1,750 to be paid within ninety

(90) days of the effective date of this decision. Failure to reimburse the Division's costs of investigation and prosecution as stated herein shall constitute a violation of the probation order, unless the Division agrees in writing to payment by a revised installment plan because of financial hardship. The filing of bankruptcy by the respondent shall not relieve the respondent of his responsibility to reimburse the Division for its investigative and prosecution costs.

12. PROBATION COSTS Respondent shall pay the costs associated with probation monitoring each and every year of probation, which are currently set at $2,304, but may be adjusted on an annual basis. Such costs shall be payable to the Division of Medical Quality and delivered to the designated probation surveillance monitor at the beginning of each calendar year. Failure to pay costs within 30 days of the due date shall constitute a violation of probation.

13. LICENSE SURRENDER Following the effective date of this decision, if respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may voluntarily tender his certificate to the Board. The Division reserves the right to evaluate the respondent's request and to exercise its discretion whether to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the tendered license, respondent will not longer be subject to the terms and conditions of probation.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Decision. I understand the effect this stipulation will have on my physician's and surgeon's certificate No. G46239 and agree to be bound thereby. I enter into this Stipulated Settlement and Decision knowingly, voluntarily, freely and intelligently.

DATED: 2/15/00

William H. Johnson, Jr., M.D.
Respondent

I have fully discussed with respondent William H. Johnson, Jr., M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Decision and approve its form and content.

Dated: 17 FEBRUARY 2000

STURGEON, KELLER, PHILIPS, GEE & O'LEARY

BROCK D. PHILLIPS, ESQ.
Attorneys for Respondent

ENDORSEMENT

The foregoing Stipulated Settlement and Decision is hereby respectfully submitted for consideration of the Division of Medical Quality, Medical Board of California, Department of Consumer Affairs.

DATED: March 15, 2000.

BILL LOCKYER, Attorney General
of the State of California

Lynne K. Dombrowski
Deputy Attorney General
Attorneys for Complainant

EXHIBIT A

BILL LOCKYER, Attorney General
of the State of California
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Attorneys for Complainant

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **WILLIAM H. JOHNSON, Jr., M.D.,** 2260 Gladstone Drive, Suite 2 Pittsburg, CA 94565 Physician's and Surgeon's Certificate No. G 46239, Respondent.	Case No. 12 97 71148 **ACCUSATION**

The Complainant alleges:

PARTIES

1. Complainant, Ronald Joseph, is the Executive Director of the Medical Board of California, State of California (hereinafter "the Board") and brings this Accusation solely in his official capacity.

2. At all times material herein, respondent, William H. Johnson, Jr., M.D., (hereinafter "respondent" or "Dr. Johnson") has held Physician's and Surgeon's Certificate No. G 46239 which was issued to him by the Board on or about September 29, 1981. Unless renewed, it will expire on February 28, 2001. No prior disciplinary action

has been taken against said Certificate. Respondent is not currently a licensed supervisor of a physician assistant.

JURISDICTION

3. This Accusation is brought before the Division of Medical Quality of the Medical Board of California, Department of Consumer Affairs (hereinafter the "Division"), under the provisions of law hereinafter set forth.

4. Section 2227 of the Code provides that a licensee who has been found guilty under the Medical Practice Act by the Division may have his license revoked, suspended for a period not to exceed one year, or placed on probation and required to pay the costs of probation monitoring, or other action may be taken against the license that the Division deems proper.

5. Section 2234 of the Code provides, in pertinent part, that the Division shall take action against any licensee who is charged with unprofessional conduct. Unprofessional conduct includes, but is not limited to, the following:

> "(b) Gross negligence.
>
> (c) Repeated negligent acts.
>
> (d) Incompetence.
>
> (e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon."

6. Section 14124.12 of the Welfare and Institutions Code states, in pertinent part, as follows:

> "(a) Upon receipt of written notice from the Medical Board of California . . . that a licensee's license has been placed on probation as a result of a disciplinary action, the department may not reimburse any Medi-Cal claim for the type of surgical service or invasive procedure that gave rise to the probation, including any dental surgery or invasive procedure, that was performed by the licensee on or after the effective date of probation and until the termination of all probationary terms and conditions or until the probationary period has ended, whichever occurs first. This section shall apply except in any case in

> which the relevant licensing board determines that compelling circumstances warrant the continued reimbursement during the probationary period of any Medi-Cal claim . . . as so described. In such a case, the department shall continue to reimburse the licensee for all procedures, except for those invasive or surgical procedures for which the licensee was placed on probation."

7. The conduct of respondent as hereinafter alleged occurred while he was practicing and/or operating offices as a physician and surgeon in private practice in or about Pittsburg.

PROVISIONS OF LAW

BUSINESS AND PROFESSIONS CODE

8. Sections 2001 and 2003 of the Business and Professions Code[1/] provides for the existence of the Board, and for the existence of the Division of Medical Quality within the Board.

9. Section 2004 provides, inter alia, that the Division is responsible for the administration and hearing of disciplinary actions involving enforcement of the Medical Practice Act (section 2000 et seq.) and the carrying out of disciplinary action appropriate to findings made by a medical quality review committee, the Division, or an administrative law judge with respect to the quality of medical practice carried out by physician & surgeon certificate holders.

10. Sections 2220, 2234 and 2227 together provide that the Division shall take disciplinary action against the holder of a physician's and surgeon's certificate who is guilty of unprofessional conduct. Section 2227 further provides that a licensee who is found guilty under the Medical Practice Act may have his license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Division deems proper.

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1. All statutory references herein are to the Business and Professions Code unless otherwise indicated.

11. Section 725 provides that repeated acts of clearly excessive prescribing or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct.

12. Section 2238 provides that a violation of any federal statute or federal regulation or any of the statutes or regulations of this state regulating dangerous drugs or controlled substances constitutes unprofessional conduct.

13. Section 2241 provides, in pertinent part, that the prescribing, selling, furnishing, giving away, or administering or offering to prescribe, sell, furnish, give away, or administer any of the drugs or compounds mentioned in Section 2239 to an addict or habitue constitutes unprofessional conduct.

14. Section 2242(a) provides that prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without a good faith prior examination and medical indication therefor, constitutes unprofessional conduct.

15. Section 2266 provides that a failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

16. Section 4022 defines a "dangerous drug", in pertinent part, as any drug unsafe for self-use, including any drug that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006.

HEALTH AND SAFETY CODE

17. Section 11153(a) of the Health and Safety Code provides that a prescription for controlled substance shall only be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his or her professional practice. Except as authorized by this division, the following are not legal prescriptions: (1) an order purporting to be a prescription which is issued not in the usual course of professional treatment or in legitimate and authorized research; or (2) an order for an addict or habitual

user of controlled substances, which is issued not in the course of professional treatment or as part of an authorized methadone maintenance program, for the purpose of providing the user with controlled substances, sufficient to keep him or her comfortable by maintaining customary use.

18. Section 11156 of the Health and Safety Code provides that no person shall prescribe for or administer, or dispense a controlled substance to an addict or habitual user, or to any person representing himself as such, except as permitted by this division.

19. Section 11171 of the Health and Safety Code provides that no person shall prescribe, administer, or furnish a controlled substance except under the conditions and in the manner provided by this division.

20. Section 11210 of the Health and Safety Code provides, in pertinent part that:

> "A physician . . . may prescribe for, furnish to, or administer controlled substances to his . . . patient when the patient is suffering from a disease, ailment, injury, or infirmities attendant upon old age, other than addiction to a controlled substance.
>
> "The physician . . . shall prescribe, furnish, or administer controlled substances only when in good faith he . . . believes the disease, ailment, injury, or infirmity requires the treatment.
>
> "The physician . . . shall prescribe, furnish, or administer controlled substances only in the quantity and for the length of time as are reasonably necessary."

COST RECOVERY

21. Section 125.3 of the Business and Professions Code provides, in part, that the Board may request the administrative law judge to direct any licentiate found to have committed a violation or violations of the licensing act, to pay the Board a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

DRUGS

22. Elavil is the trade name for Amitriptyline Hydrochloride and is a dangerous drug as defined in section 4022. Elavil is indicated for use as an anti-depressant and has sedative side effects.

23. Paxil is the trade name for Paroxetine Hydrochloride and is a dangerous drug as defined in section 4022. Paxil is indicated for use as an antidepressant and in the treatment of obsessive compulsive disorder and panic disorder.

24. Phentermine Hydrochloride is manufactured under the trade names Adipex-P, Fastin, Ionamin, Obestin-30, and Phentrol. Phentermine is a Schedule IV controlled substance under section 11057(f)(2) of the Health and Safety Code and a dangerous drug as defined in section 4022. Phentermine is an anorectic drug that stimulates the central nervous system and is indicated for use as a short-term adjunct in a regimen of weight reduction based on exercise, behavioral modification and caloric restriction in the management of exogenous obesity. Phentermine is contraindicated for patients in agitated states or with a history of drug abuse.

25. Soma is the trade name for Carisoprodol and is a dangerous drug as defined in section 4022. Soma is a muscle-relaxant and sedative and has additive effects when taken with alcohol, central nervous system depressants, or psychotropic drugs.

26. Temazepam is manufactured under the trade name Restoril and is a benzodiazepine hypnotic agent and a schedule IV controlled substance and narcotic as defined by section 11057(d) of the Health and Safety Code and by Section 1308.14 of Title 21 of the Code of Federal Regulations and a dangerous drug as defined in section 4022. Temazepam is indicated for use as a short-term treatment of insomnia, generally 7-10 days. Temazepam may have additive effects when taken in combination with alcohol or other central nervous system depressants.

27. Vicodin or Vicodin ES are trade names for a combination of Hydrocodone Bitartrate and Acetaminophen and is a semi-synthetic narcotic analgesic. Vicodin/Vicodin ES is a Schedule III controlled substance and narcotic as defined by section 11056(e) of the Health and Safety Code and section 1308.13 (e) of Title 21 of the Code of Federal Regulations and is a dangerous drug as defined in section 4022. Vicodin/Vicodin ES may have additive effects on central nervous system depression when taken in combination

with other narcotic analgesics, antipsychotic or antianxiety drugs, alcohol or other central nervous system depressants.

28. Xanax is the trade name for Alprazolam and is a schedule IV controlled substance and narcotic as defined by section 11057(d) of the Health and Safety Code and by Section 1308.14 (c) of Title 21 of the Code of Federal Regulations, and a dangerous drug as defined in section 4022. Xanax has a central nervous system depressant effect, is used for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety.

29. Zoloft is the trade name for Sertraline Hydrochloride and is a dangerous drug as defined in section 4022. Zoloft is indicated for use in the treatment of depression.

FIRST CAUSE FOR DISCIPLINARY ACTION

(Re: Patient A.R[2/])

30. On or about August 16, 1994, respondent first saw patient A.R., a then 20-year-old female, for treatment of acne. Respondent did not record a physical examination or patient medical history for patient A.R..

31. On or about March 6, 1995 and April 3, 1995, respondent "re-filled" a prescription for #50 Xanax tablets for patient A.R. without any record of an original prescription and without any documented physical examination or medical indication therefor.

32. According to respondent's medical records, he next saw patient A.R. two years later, on or about April 2, 1997. Patient A.R. complained of severe stress, alleging that her son had been molested by a neighbor. Respondent has no documented record of a physical examination, a list and evaluation of the patient's symptoms, or a recommended treatment plan. Respondent prescribed Xanax 1 mg tablets to be taken one or two times per day. Respondent did not document the quantity of Xanax dispensed.

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2. For the protection of the patients' right to privacy, the full names of patients will be disclosed in discovery.

33. In May 1997 through July 1997, respondent did not see or examine patient A.R., yet respondent prescribed at least #165 Xanax 1 mg tablets for patient A.R.. There is no documentation in respondent's medical records of these prescriptions and no documented medical indication therefor.

34. On or about August 4, 1997, respondent saw patient A.R. and it was noted that she had increased her Xanax use to four times daily "some days". Respondent did not document any discussion about the patient's Xanax use or any medical indication for its use.

35. On or about August 11, 1997, respondent saw patient A.R. for suture removal. There is no record of the placement of sutures in respondent's records. Respondent did not document any physical complaints from patient A.R. and does not document any discussion of the patient's use of Xanax.

36. In August 1997, respondent prescribed approximately #120 Xanax 1 mg tablets for patient A.R.. There is no documentation in respondent's medical records of these prescriptions and no medical indication therefor.

37. From about September 1997 until about April 21, 1998, respondent did not see or examine patient A.R.. Yet, respondent prescribed approximately #750 Xanax 1 mg tablets for patient A.R.. One pharmacy's records indicate that respondent was initially prescribing for patient A.R. #15 Xanax 1 mg tablets about every 7 days. Starting in about November 1997, respondent began prescribing #60 Xanax 1 mg tablets every 14-20 days. There is no documentation in respondent's medical records of these prescriptions and no medical indication therefor.

38. On or about April 14, 1998, respondent's records indicate that patient A.R. telephoned respondent's office and was upset and verbally abusive regarding a Xanax refill denial. Respondent prescribed #16 Xanax 1 mg tablets on that day for patient A.R..

39. On or about April 21, 1998, respondent saw patient A.R. who complained of having the flu. Respondent noted that patient A.R. was taking Xanax two to

four times daily. Respondent further documented that A.R. was using up to three Xanax tablets at one dose, although he was aware that the patient was actually using more than that, actually 14 to 15 tablets daily. Respondent made no record of taking a physical history or performing a physical examination. He noted that patient A.R. had severe anxiety, depression, and was jittery without noting any physical or psychological symptoms. Respondent prescribed the antidepressant #30 Trazadone 50 mg and refilled the prescription of #60 Xanax 1 mg without a documented medical indication therefor and despite the information provided by patient as to her abuse of the prescribed medications.

40. On or about May 13, 1998, respondent saw patient A.R. who continued to complain of the flu, anxiety and "jitters". Respondent made no record of taking a physical history or performing a physical examination. Respondent prescribed #60 Xanax 1 mg tablets and #30 Elavil 25 mg tablets without a documented physical examination and a medical indication therefor.

41. On or about June 29, 1998, respondent sent two prescriptions of Xanax, 60 tablets each, to Thrifty pharmacy for patient A.R. who picked up both prescriptions. Respondent did not document an examination of the patient, has no documented medical indication therefor, and has no record of the prescriptions in the patient's medical records.

42. On or about July 9, 1998, patient A.R. telephoned respondent's office and accused the office of sending her an insulting newspaper article.

43. On or about July 30, 1998, after respondent received a subpoena from the Medical Board for patient A.R.'s medical records, respondent created a typewritten "medical note" for patient A.R.'s file in which he noted, among other things, that there was some evidence of the patient's abuse of her prescribed medication. Respondent's written medical records for patient A.R., however, do not document a review of the patient's history of substance abuse, pertinent family history, or risk factors for substance abuse and do not

document any discussion with the patient about this abuse or any attempts by respondent to assess and treat the problem.

44. Between May 14, 1998 and August 1998, respondent did not see or examine patient A.R.. Yet, respondent prescribed about #300 Xanax 1 mg tablets and #90 Elavil for patient A.R.. There is no documentation in respondent's medical records of these prescriptions and no medical indication therefor.

ACTS OR OMISSIONS RE PATIENT A.R.

45. Respondent committed the following acts or omissions in the treatment of Patient A.R.:

A. Respondent failed to perform and/or document an adequate and complete medical and psycho-social history and/or physical examinations and/or diagnostic tests on patient A.R. including, but not limited, to a history of substance abuse and current uses of drugs and alcohol, and assessments of the patient's risk for substance abuse and addiction; and/or

B. Respondent failed to develop and/or document the development of a treatment plan with stated objectives and a periodic review and evaluation of the progress of his treatment plan; and/or

C. Respondent failed to adequately document a medical indication for the prescribing and use of a controlled substance, Xanax; and/or

D. Respondent failed to adequately provide and/or document that patient A.R. was fully advised about her treatment and that she gave full informed consent regarding her treatment and medications; and/or

E. Respondent failed to keep adequate and/or accurate records regarding respondent's prescriptions and refills, including the type and the amounts, dispensed to patient A.R. and the patient's use of the prescribed controlled substances; and/or

F. Respondent prescribed increased and/or excessive amounts of the controlled substance Xanax without adequately documenting or following accepted guidelines, and/or without adequately documenting and/or performing proper monitoring, and/or without performing and/or documenting periodic review of the course of treatment; and/or

G. Respondent failed to keep adequate and/or accurate records regarding respondent's prescriptions and refills, the type and the amounts, dispensed to patient A.R. and the patient's use of the prescribed dangerous drugs and controlled substances; and/or

H. Respondent repeatedly prescribed clearly excessive amounts of the controlled substance Xanax without a medical indication, and/or without a properly documented medical indication therefor; and/or

I. Respondent failed to recognize and/or treat, by intervention, referral, or otherwise, patient A.R.'s abuse and/or dependence on Xanax and failed to adequately intervene and treat or refer the patient for treatment and counseling when the patient exhibited symptoms of addiction and/or exhibited paranoid and aggressive behavior; and/or

J. Respondent showed a lack of knowledge and/or incompetence in the treatment of drug abuse and addiction and anxiety and depression.

VIOLATIONS RE PATIENT A.R.

(Unprofessional Conduct/Gross Negligence/Incompetence)

46. Respondent's conduct as set forth in paragraphs 31 through 45 hereinabove constitutes general unprofessional conduct and/or gross negligence and/or incompetence and is cause for disciplinary action pursuant to sections 2234, 2234(b), and/or 2234(d).

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SECOND CAUSE FOR DISCIPLINARY ACTION

(Re: Patient A.R.: Failure to Maintain Adequate Records)

47. Respondent's conduct as set forth in paragraphs 33 through 45 hereinabove constitutes unprofessional conduct in that he failed to maintain adequate and accurate records relating to the provision of services to patient A.R. and is cause for discipline pursuant to section 2266.

THIRD CAUSE FOR DISCIPLINARY ACTION

(Re: Patient A.R.: Dishonest or Corrupt Acts re: Medical Records)

48. Respondent's conduct as set forth in paragraphs 31 through 45 hereinabove constitutes the commission of any act(s) involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon and is cause for disciplinary action pursuant to section 2234(e).

FOURTH CAUSE FOR DISCIPLINARY ACTION

(Re: Patient A.R.: Repeated Acts of Excessive Prescribing)

49. Respondent's conduct as set forth in paragraphs 31 through 45 hereinabove constitutes repeated acts of clearly excessive prescribing or administering of drugs or treatment or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees and is cause for disciplinary action pursuant to section 725.

FIFTH CAUSE FOR DISCIPLINARY ACTION

(Re: Patient A.R.: Prescribing to an Addict/Habitual User)

50. Respondent's conduct as set forth in paragraphs 31 through 45 hereinabove constitutes the prescribing or administering of drugs to an addict or habitual user and is cause for disciplinary action pursuant to section 2241 and to section 2238 in conjunction with section 11156 of the Health and Safety Code.

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SIXTH CAUSE FOR DISCIPLINARY ACTION

(Re: Patient A.R.: Prescribing Without a Good Faith Exam and a Medical Indication)

51. Respondent's conduct as set forth in paragraphs 31 through 45 hereinabove constitutes the prescribing, dispensing, or furnishing of dangerous drugs without a good faith examination and medical indication therefor and is cause for disciplinary action pursuant to section 2242(a).

SEVENTH CAUSE FOR DISCIPLINARY ACTION

(Re: Patient A.R.: Excessively Prescribing Controlled Substances)

52. Respondent's conduct as set forth in paragraphs 31 through 45 hereinabove constitutes the prescribing of controlled substances in excess of such quantity and length of time as is reasonably necessary and is cause for disciplinary action pursuant to section 2238 in conjunction with section 11210 of the Health and Safety Code.

EIGHTH CAUSE FOR DISCIPLINARY ACTION

(Re: Patient A.R.: Prescribing Without a Legitimate Medical Purpose)

53. Respondent's conduct as set forth in paragraphs 31 through 45 hereinabove constitutes prescribing, dispensing, or furnishing controlled substances without a legitimate medical purpose and therefore is cause for disciplinary action pursuant to section 2238 in conjunction with section 11153(a) of the Health and Safety Code.

NINTH CAUSE FOR DISCIPLINARY ACTION

(Re: Patient L.S.)

54. In or about February 1984, respondent first saw patient L.S., a then 26 year-old female. Patient L.S. was morbidly obese and respondent counseled her regarding diet. Respondent made no record of a patient medical history and made no record of a treatment plan and no record of prescriptions written for patient L.S..

55. Respondent has no records of examining or treating patient L.S. for about five years, from about November 1988 until about January 1994.

56. On or about January 6, 1994, respondent saw patient L.S. who complained of shortness of breath, coughing, wheezing, a cold, runny nose and congestion. Respondent's notes in the medical record indicate an assessment of bronchitis and chronic obstructive pulmonary disease, morbid obesity, anxiety, depression and panic attack, and a plan to refer to a psychiatrist. Respondent failed to document a medical history and an adequate physical examination with a list of physical symptoms to support a diagnosis. Respondent noted that patient L.S. was taking one .25 mg Xanax tablet twice daily, 40 mg Prozac once daily and "occasional Vicodin as needed". Respondent's records do not indicate from whom the patient obtained said controlled substances. Respondent failed to adequately document the medications he prescribed for patient L.S. and their amounts and a medical indication therefor.

57. On or about January 20, 1994, respondent apparently prescribed for patient L.S. #60 Xanax 0.5 mg tablets and #60 Vicodin. Respondent did not perform a physical examination or otherwise see patient L.S. and did not document symptoms and a medical indication for said prescriptions.

58. On or about February 17, 1994, respondent, without examining the patient and/or documenting a medical reason, prescribed additional refills of, among other medications, #60 Xanax 0.5 mg and #20 Prozac 40 mg.

59. Respondent saw patient L.S. on or about March 29, April 12, and May 19, 1994. At each visit, patient L.S. complained of continued coughing, wheezing and shortness of breath. Respondent failed to conduct and/or document an adequate physical examination and record symptoms, a treatment plan, and the medications and amounts prescribed.

60. On or about June 13, 1994, respondent prescribed by telephone for patient L.S., without a physical examination or a documented medical indication, #40 Xanax tablets at an increased dosage of 1 mg.

61. On or about June 16, 1994, respondent's typed patient evaluation indicates a need to follow-up with the patient's asthma and wheezing. Respondent also notes that the patient is "recommended to follow-up with Health Management Medical Group for weight loss." Respondent failed to perform and/or document an adequate physical examination of the patient.

62. On or about July 18, 1994, patient L.S. saw a psychiatrist on respondent's referral. The psychiatrist advised respondent that he would prescribe antidepressants for patient L.S.. Respondent was later advised that patient L.S. did not make any further visits to the psychiatrist.

63. Without seeing patient L.S. and documenting a physical examination and a medical indication therefor, respondent prescribed #40 Vicodin on July 22, 1994, #60 Xanax 1 mg. on July 27, 1994, and #20 Vibramycin 100 mg on August 1, 1994.

64. On or about August 1, 1994, patient L.S. was seen at the emergency room at Delta Memorial Hospital for asthma, anxiety and obesity.

65. On or about August 11, 1994, respondent saw patient L.S. who complained of depression, recurrent panic attacks, wheezing, and shortness of breath. The patient indicated that her husband had left her. Respondent's records state that patient L.S. was using four to six pills of Xanax per day with noted decreased effect and with increased agoraphobia and fear. There was no charting by respondent as to the total quantity of medications used or prescribed. Respondent's medical records indicate that patient L.S. was to continue with Xanax at 1 mg doses three times a day and Prozac 40 mg daily with a plan to prescribe Efflexor and Buspar.

66. Respondent's records include a copy of a prescription dated September 12, 1994 for #180 Xanax 1 mg tablets to be taken three times daily. This prescription was written for patient L.S. by her psychiatrist.

67. On or about September 15, 1994, respondent, without seeing or examining patient L.S., prescribed by telephone #10 Ambien 10 mg. and #24 Efflexor without a documented medical indication therefor.

68. On or about October 3, 1994, respondent saw patient L.S. who complained, among other things, that she was a nervous wreck, that the medications were not helping, and that Efflexor was causing her nausea. Respondent noted in the patient's medical records that he planned, and obtained approval, to refer patient L.S. for a psychiatric evaluation.

69. On or about October 18, 1994, respondent saw patient L.S. for a visit. Respondent failed to document a physical examination, an evaluation of physical symptoms, and any medical indication for the prescriptions and amounts prescribed. Respondent prescribed an increased dosage of 2 mg Xanax 3 to four times daily and 100 mg Zoloft daily.

70. On or about October 25, 1994, respondent's records reflect that patient L.S. was authorized to participate in a sleep study on or about November 1, 1994. Respondent's records contain no follow-up regarding this referral.

71. Respondent's medical records for patient L.S. document that, on or about November 17, 1994, respondent was informed by patient L.S.'s psychiatrist that patient L.S. had slit her wrist and was referred for emergency psychiatric evaluation.

72. On or about November 21, 1994, respondent saw patient L.S. and noted that she was near psychotic. Nothing in respondent's records reflect a physical examination or observed psychological symptoms or a specific plan to refer the patient for psychiatric counseling and treatment. Respondent prescribed 100 mg Zoloft daily, 1 mg Xanax four to six times daily and Ambien without a documented medical indication therefor.

73. Respondent's medical records after November 1994 for patient L.S. make no further mention of psychiatric treatment or consultation or monitoring regarding patient's suicidal behavior.

74. Between November 21, 1994 and February 10, 1995, respondent has no record of seeing or examining patient L.S..

75. On or about February 10, 1995, respondent saw patient L.S. who presented with a burn on her left leg and congestion. Respondent did not document an adequate physical examination of the patient. Respondent failed to adequately document a medical indication and the quantities of the medications prescribed: Buspar, Xanax and Zoloft.

76. On or about April 24, 1995, respondent saw patient L.S. who complained of shortness of breath, soreness in chest, dizziness, tiredness, and wheezing. Respondent noted a referral to a psychiatrist. Respondent failed to perform and/or document a physical examination and a medical indication for the prescriptions issued for Ceclor, 1 mg Xanax, #40 Vicodin four times daily, and 200 mg Zoloft daily.

77. On or about May 16, 1995, respondent saw patient L.S. who complained of a continued cough and indicated that she had gone to the emergency room at Delta Memorial Hospital about a week prior with an asthma attack. Respondent failed to perform and/or document an adequate physical examination and a treatment plan. Respondent prescribed Zoloft without documenting the quantity prescribed and a medical indication therefor.

78. On or about May 19, 1995, respondent prescribed, without seeing or examining patient L.S., #40 Vicodin without a medical indication therefor.

79. On or about June 5, 1995, respondent saw patient L.S. but did not document an adequate physical examination. Respondent noted that the patient was hypoglycemic and that he would stop prescribing Zoloft. Respondent also ordered laboratory work, which tests revealed, among other things, a high cholesterol count.

80. On or about June 20, 1995, respondent saw patient L.S. and noted that he "reviewed labs" without any further documentation as to what the labs revealed and to his

treatment plan. Respondent's records indicate that he prescribed additional Xanax but without documenting the quantity prescribed and a medical indication therefor.

81. On or about August 14, 1995, respondent, without seeing or examining patient L.S., refilled a prescription for Zoloft, without documenting a medical reason therefor and in direct contradiction to his note on June 5, 1995.

82. On or about August 12, 1995, patient L.S. was seen at the emergency room at Mount Diablo Medical Center for anxiety and depression associated with her weight problem. The hospital records indicate that the patient was diagnosed with anxiety and depression and a non-insulin dependent diabetes mellitus.

83. On or about August 29, 1995, patient L.S. was seen at the emergency room at Delta Memorial Hospital for back pain, was diagnosed with a gall bladder problem.

84. On or about August 31, 1995, respondent saw patient L.S. who complained of a cold, cough, and anxiety. Respondent noted a request for another referral to a psychiatrist and that he discontinued Zoloft. Respondent had laboratory work done which indicated, among other things, a high cholesterol count. Respondent failed to perform and/or document an adequate physical examination and a treatment plan.

85. On or about September 11, 1995, respondent's medical records indicate that, without seeing or examining patient L.S., that he prescribed by telephone Xanax, Wellbutrin, and Vicodin ES without a medical indication and without documenting the quantities prescribed.

86. On or about September 12, 1995, respondent became aware that patient L.S.'s psychiatrist prescribed #180 Xanax.

87. On or about September 18, 1995, respondent saw patient L.S. who complained of severe stress and depression, she had recently filed divorce papers. Respondent failed to perform and/or adequately document a physical examination, the patient's physical symptoms, a treatment plan, and/or prescriptions issued.

88. On or about November 2, 1995, patient L.S. was seen in respondent's office and complained that she had been struck in the face by her husband and had increased nervousness. Respondent noted that Xanax was not helpful.

89. On or about November 14, 1995, respondent performed a laparoscopic cholecystectomy with cholangiogram on patient L.S.. Respondent's medical records for patient L.S. contain no operative report, no pre- or post-operative examinations or tests, and no documentation of the patient's informed written consent.

90. On or about December 1, 1995, respondent saw patient L.S. who complained of lower back pain. Respondent diagnosed a urinary tract infection and vaginitis. Respondent's medical records indicate a prescription for Floxin without documenting the quantity prescribed and a medical indication therefor.

91. On or about January 4, 1996, respondent prescribed #90 Vicodin ES and other medications for patient L.S. without documenting a physical examination or medical indication therefor.

92. On or about June 20, 1996, respondent saw patient L.S. who complained of fatigue, stress, and a cough. Respondent failed to perform and/or document a physical examination yet diagnosed a urinary tract infection. Respondent prescribed Paxil and Xanax without documenting the quantities and the medical reason.

93. On or about January 10, 1997, patient L.S. arrived by ambulance at the emergency room at Sutter Delta Medical Center in Antioch. Patient L.S presented with progressive dyspnea (difficult breathing) and acute respiratory acidosis. Another physician diagnosed her with obesity, hypoventilation syndrome and obstructive sleep apnea. Patient L.S. was discharged on or about January 13, 1997 and was scheduled to participate in a sleep study and to follow-up with respondent. The hospital physician prescribed #30 Paxil and #30 Vicodin.

94. From January 1997 until April 1997, respondent did not see or examine patient L.S.. Yet, respondent prescribed, among other drugs, approximately #360 Xanax, #285 Vicodin, and #60 Paxil.

95. On or about July 28, 1997, respondent saw patient L.S. who reported a fall on 6/6/97 in her bathroom and presented with mid-back pain and lice. Respondent failed to perform and/or document a physical examination and diagnostic tests. Respondent prescribed #60 Vicodin ES, #60 Soma 350 mg, and Prozac 2mg without a medical indication therefor and without documenting the amount of Prozac dispensed.

96. On or about September 8, 1997, respondent saw patient L.S. who complained of being very stressed and of panic attacks. L.S. informed respondent of an overdose/suicide attempt on September 4, 1997. She said she took an excess of Soma and Xanax and was taken to Delta Memorial Hospital. Respondent failed to perform and/or document a physical examination. Respondent noted a diagnosis of depression and anxiety. Despite the patient's attempted suicide, respondent prescribed Xanax, Vicodin, and Paxil without documenting the quantities prescribed, an adequate treatment plan, and a medical indication therefor.

97. Pharmacy records show that, in the month of September 1997, respondent prescribed at least #180 Xanax, #180 Vicodin, and #60 Paxil to patient L.S. without a documented medical indication therefor.

98. In October and November 1997, respondent did not document seeing, examining, or prescribing for patient L.S.. However, pharmacy records show that, in October and November 1997, respondent prescribed to patient L.S. #360 Xanax, #180 Vicodin, #120 Soma, and #40 Temazepam.

99. On or about December 10, 1997, respondent saw patient L.S. who presented with anxiety, depression and "crisis". Respondent failed to perform and/or document a physical and psycho-social examination. Respondent prescribed Xanax and Paxil without documenting the quantities prescribed and the medical indication therefor.

100. Pharmacy records show that, in December 1997, respondent prescribed for patient L.S. #180 Xanax, #60 Soma, #90 Vicodin, #60 Paxil, and #20 Temazepam. Respondent's records fail to document the amounts of these prescribed drugs and the medical indication therefor.

101. On or about January 29, 1998, respondent saw patient L.S. who complained of chest congestion, sore throat, and fatigue. Respondent failed to perform and/or document a physical examination, a treatment plan, and prescriptions issued. Yet, respondent charted a first reference to L.S.'s chronic pain without substantiating this diagnosis with an adequate documentation of symptoms, exam and evaluation.

102. On or about March 25, 1998, respondent saw patient L.S. who complained of falling two times in two weeks. Respondent failed to perform and/or document a physical examination, a treatment plan, and the type and quantity of prescriptions issued.

103. On or about April 27, 1998, respondent saw patient L.S. whose only recorded complaint was shortness of breath for two weeks. Respondent failed to perform and/or document a physical examination. Respondent's only charted assessment was hypertension. Respondent prescribed Vicodin ES and #30 Phentermine 30 mg diet pills without documenting the quantity prescribed of Vicodin, a treatment plan, and medical indications therefor.

104. On or about May 28, 1998, respondent certified in writing that patient L.S. needed in-home supportive services for respiratory care, three times daily. Respondent failed to document any subsequent monitoring and/or follow-up to this in-house care.

105. On or about June 17, 1998, respondent saw patient L.S. but failed to perform and/or document an adequate physical examination and/or record of symptoms and/or assessment of a treatment plan. Respondent continued to prescribe Phentermine. Despite the charted continuation of the patient's anxiety, depression, stress, chest pain,

shortness of breath, dizziness and the severity and multiplicity of complaints, Respondent did not generate a complete history and evaluation of the patient.

106. On or about June 29, 1998, respondent saw patient L.S. who complained of dizziness, pain, cough, shortness of breath, mild anxiety, depression and stress. Respondent failed to perform and/or document a physical examination and the prescriptions and amounts issued.

107. On or about July 30, 1998, after respondent received a subpoena from the Medical Board for patient L.S.'s medical records, respondent created a typewritten "medical note" for patient L.S.'s file regarding a summary of his treatment. Respondent's written medical records for patient L.S., however, do not adequately substantiate this information.

ACTS OR OMISSIONS RE PATIENT L.S.

108. Respondent committed the following acts or omissions in the treatment of Patient L.S.:

A. Respondent failed to perform and/or document an adequate and complete medical and psycho-social history and/or physical examinations and/or diagnostic tests on patient L.S. including, but not limited to, a history of substance abuse and current uses of drugs and alcohol and assessments of the patient's risk for substance abuse and addiction; and/or

B. Respondent failed to develop and/or document the development of a treatment plan with stated objectives and a periodic review and evaluation of the progress of his treatment plan; and/or

C. Respondent failed to adequately document a medical indication for the prescribing and use of controlled substances, including Temazepam, Xanax and/or Vicodin; and/or

D. Respondent failed to adequately provide and/or document that patient L.S. was fully advised about her treatment and that she gave full informed consent regarding

her treatment and medications; and/or prolonged use of tranquilizers and a discussion of alternative and supportive therapies; and/or

E. Respondent prescribed increased and/or excessive amounts of controlled substances without adequately documenting or following standard prescribing guidelines, and/or without adequately documenting and/or performing proper monitoring, and/or without performing and/or documenting periodic review of the course of treatment; and/or

F. Respondent failed to keep adequate and/or accurate records regarding respondent's prescriptions and refills, including the type and the amounts, dispensed to patient L.S. and the patient's use of the prescribed dangerous drugs and controlled substances; and/or

G. Respondent repeatedly prescribed clearly excessive amounts of controlled substances including, but not limited to, tranquilizers without a medical indication, and/or without a properly documented medical indication therefor; and/or

H. Respondent failed to adequately monitor and/or minimize the prescribing of controlled substances used in a patient with repeated suicide attempts and demonstrated a lack of knowledge or incompetence in failing to recognize that increased amounts would put the patient at greater risk; and/or

I. Respondent demonstrated a lack of knowledge and/or incompetence in failing to recognize the potential for severe emotional and physical dependence on Xanax when taken in doses greater than 4 mg daily; and/or

J. Respondent improperly prescribed the regular use of sleeping pills and/or a muscle relaxant Soma to patient L.S. despite her history of abuse of narcotics and tranquilizers; and/or

K. Respondent failed to adhere to the standard of practice for weight loss management in failing to properly regulate the use of appetite suppressants and in prescribing and refilling monthly doses of Phentermine without adequately performing and/or documenting treatment goals, the patient's progress, and/or concurrent supportive therapy,

and despite patient L.S.'s demonstrated high risk for abusing controlled and addictive substances; and/or

L. Respondent prescribed and refilled increased and/or excessive amounts of Vicodin ES for patient L.S. without adequately performing and/or documenting an assessment of and treatment plan for management of the pain for which it was prescribed, and/or without performing and/or documenting diagnostic evaluations and/or trial of therapeutic alternatives and/or referral to a specialist and/or discussion of pain management alternatives with the patient; and/or

M. Respondent failed to adequately perform and/or document a regular monitoring and treatment of patient L.S.'s diabetic condition; and/or

N. Respondent failed to adequately perform and/or document a regular monitoring and treatment of patient L.S.'s hypoventilation syndrome and demonstrated a lack of knowledge and/or incompetence by failing to recognize that escalating dosages of controlled substances compounded the patient's problem and could be life-threatening; and/or

O. Respondent failed to adequately perform and/or document a regular monitoring and treatment of patient L.S.'s high cholesterol condition; and/or

P. Respondent failed to adequately perform and/or document a substance abuse history and/or psycho-social history and/or risk of abuse assessment on patient L.S.; and/or

Q. Respondent failed to adhere to the standard of practice by prescribing multiple drugs in combination which are known to have additive sedative and depressive effects, and/or by prescribing drugs recommended for short-term therapy for an ongoing long-term basis without documenting a medical indication therefor; and/or

R. Respondent demonstrated a lack of knowledge and/or incompetence in the treatment of drug abuse and addiction, anxiety and depression, diabetes, hypoventilation syndrome, and obesity.

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VIOLATIONS RE PATIENT L.S

(Unprofessional Conduct/Gross Negligence/Incompetence)

109. Respondent's conduct with regard to patient L.S., as set forth in paragraphs 56 through 108 hereinabove, constitutes general unprofessional conduct and/or gross negligence and/or incompetence and is cause for disciplinary action pursuant to sections 2234, 2234(b), and/or 2234(d).

TENTH CAUSE FOR DISCIPLINARY ACTION

(Re: Patient L.S.: Failure to Maintain Adequate Records)

110. Respondent's conduct as set forth in paragraphs 56 through 108 hereinabove constitutes unprofessional conduct in that he failed to maintain adequate and accurate records relating to the provision of services to L.S. and is cause for discipline pursuant to section 2266.

ELEVENTH CAUSE FOR DISCIPLINARY ACTION

(Re: Patient L.S.: Dishonest or Corrupt Acts re: Medical Records)

111. Respondent's conduct as set forth in paragraphs 56 through 108 hereinabove constitutes the commission of any act(s) involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon and is cause for disciplinary action pursuant to section 2234(e).

TWELFTH CAUSE FOR DISCIPLINARY ACTION

(Re: Patient L.S.: Repeated Acts of Excessive Prescribing)

112. Respondent's conduct as set forth in paragraphs 56 through 108 hereinabove constitutes repeated acts of clearly excessive prescribing or administering of drugs or treatment or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees and is cause for disciplinary action pursuant to section 725.

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THIRTEENTH CAUSE FOR DISCIPLINARY ACTION

(Re: Patient L.S.: Prescribing to an Addict/Habitual User)

113. Respondent's conduct as set forth in paragraphs 56 through 108 hereinabove constitutes the prescribing or administering of drugs to an addict or habitual user and is cause for disciplinary action pursuant to section 2241 and to section 2238 in conjunction with section 11156 of the Health and Safety Code.

FOURTEENTH CAUSE FOR DISCIPLINARY ACTION

(Re: Patient L.S.: Prescribing Without a Good Faith Medical Exam and a Medical Indication)

114. Respondent's conduct as set forth in paragraphs 56 through 108 hereinabove constitutes the prescribing, dispensing, or furnishing of dangerous drugs without a good faith examination and medical indication therefor and is cause for disciplinary action pursuant to section 2242(a).

FIFTEENTH CAUSE FOR DISCIPLINARY ACTION

(Patient L.S.: Excessively Prescribing Controlled Substances)

115. Respondent's conduct as set forth in paragraphs 56 through 108 hereinabove constitutes the prescribing of controlled substances in excess of such quantity and length of time as is reasonably necessary and is cause for disciplinary action pursuant to section 2238 in conjunction with section 11210 of the Health and Safety Code.

SIXTEENTH CAUSE FOR DISCIPLINARY ACTION

(Patient L.S.: Prescribing Without a Legitimate Medical Purpose)

116. Respondent's conduct as set forth in paragraphs 56 through 108 hereinabove constitutes prescribing, dispensing, or furnishing controlled substances without a legitimate medical purpose and therefore is cause for disciplinary action pursuant to section 2238 in conjunction with section 11153(a) of the Health and Safety Code.

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SEVENTEENTH CAUSE FOR DISCIPLINARY ACTION

(Re: Patient L.D.)

117. In or about February 1986, respondent first saw Patient L.D., a then 26-year-old female, who was morbidly obese and complained of a chest cold. Respondent did not document a medical history.

118. On or about March 2, 1989, patient L.D. was evaluated for back and leg pain by a neurosurgeon at UCSF who reported that the patient had no neurological disability and that the main issue in patient's pain and care was her weight. He recommended discontinuing Valium and using a tricyclic antidepressant. He referred patient L.D. directly to a pain management clinic. Respondent's records for L.D. are unclear whether she ever followed through with the referral and there is no documentation that respondent followed-up on a pain management consultation. No discussion about weight reduction or about alternative therapeutic modalities was charted by respondent.

119. In August of 1991, L.D. was diagnosed with uterine carcinoma. Patient L.D. refused surgical treatment and received radiation therapy in about May through September of 1992. Respondent's medical records do not document whether patient L.D. ever completed her course of radiation therapy.

120. On or about January 14, 1993, respondent saw patient L.D. who complained of recurring leg pain. Respondent failed to document an adequate physical examination or a treatment plan.

121. On or about March 29, 1994, respondent saw patient L.D. who complained that her "heart feels funny". Respondent made no notation regarding pertinent review of systems, history, or examination. Respondent prescribed Mevacor.

122. On or about June 27, 1994, respondent changed the prescribed medication to Lopid without documenting a medical indication therefor.

123. On or about July 20, 1995, respondent noted the patient's conditions of diabetes and hyperlipidemia but did not further document a physical examination, an

assessment of symptoms, and/or a monitoring of the treatment for these two medical conditions. Although not well-documented by respondent in his medical records, patient L.D.'s medical history apparently included type II diabetes mellitus, hyperlipidemia, and degenerative joint disease of the spine.

124. On or about February 9, 1995, patient L.D. reported to respondent nervousness, depression, and trouble sleeping. Respondent noted in the medical records "insomnia secondary to narcotics".

125. On or about May 23, 1995, respondent first prescribed Xanax for patient L.D. by telephone, without a documented physical examination and a medical indication therefor.

126. On or about May 20, 1996, respondent created a typewritten "medical evaluation" of patient L.D. in which respondent stated that patient L.D. was disabled secondary to poor ambulatory ability. Respondent found a poor prognosis and stated that patient L.D. suffered from: supermorbid obesity and degenerative disease of the lumbar spine and cervical spine; uterine carcinoma; cervical degenerative arthritis; supermorbid obesity; diabetes mellitus; hyperlipidemia; and anxiety depression disorder. Respondent's written medical records for patient L.D., however, do not adequately substantiate this information and do not document adequate treatment for the stated conditions.

127. On or about November 22, 1996, respondent's records indicate that patient L.D. requested another refill of Vicodin ES and "admitted that she is addicted to the medications now".

128. Despite the indications of patient L.D.'s addiction and/or dependence on the controlled substances, respondent prescribed for patient L.D. from January 1997 until April, 1997, approximately #270 Xanax and #360 Vicodin ES without a documented physical examination and a medical indication therefor.

129. In or about March 1997, respondent added #60 Neurontin monthly to the treatment regimen for patient L.D. without a documented physical examination and a medical indication therefor.

130. On or about May 7, 1997, respondent prescribed a sleeping pill prescription for patient L.D. without documenting an adequate physical examination and a medical indication therefor.

131. On or about May 28, 1997, patient L.D. reported to respondent that she was sexually assaulted and respondent diagnosed vaginitis. Respondent failed to document any further details, an adequate physical examination of her injuries, whether a police report was filed, and/or a recommendation of counseling as part of the patient's treatment.

132. On or about June 26, 1997, patient L.D. complained of memory loss, anxiety, stress and a loss of consciousness. She reported having been seen in a hospital emergency room. Respondent's note stated that patient L.D. "took crack". The examination charted by respondent was extremely brief and incomplete and did not include a neurological examination. Respondent's only documented assessment was a urinary tract infection to be treated with an antibiotic. There was no other evaluation, assessment, or documentation of the patient's controlled substance use.

133. On or about July 9, 1997, L.D. reported yet another assault occurring on July 4, 1997 and questioned whether she had a concussion. She also reported to respondent that she was seen in the emergency room the day before for abdominal pain with a possible diagnosis of kidney stone. Respondent did not document a physical examination of the patient. Respondent's diagnosis was "venous insufficiency, rule out kidney stone". Respondent noted in the medical chart that the patient was taking 6-8 Xanax daily.

134. In or about July 1997 through November 1997, respondent prescribed to patient L.D. approximately #830 Xanax 1 mg tablets, #360 Vicodin, and #190 Temazepam without a documented physical examination and a medical indication therefor.

135. On or about December 10, 1997, respondent charted "chronic pain treatment - stable - refill vicodin" in patient L.D.'s medical chart but failed to document the dosage, quantity, and/or an adequate physical examination and assessment.

136. In or about December 1997, respondent prescribed to patient L.D. approximately #360 Xanax, #240 Vicodin ES and #90 Temazepam without a documented physical examination and a medical indication therefor.

137. On or about December 30, 1997, patient L.D. reported to respondent that she made another emergency room visit for a tailbone injury. Without documenting an adequate physical examination and/or a medical indication therefor, respondent prescribed a Vicodin refill of #120 tablets.

138. On or about July 30, 1998, after respondent received a subpoena from the Medical Board for patient L.D.'s medical records, respondent created a typewritten "medical note" for patient L.D.'s file. Respondent claimed that he reviewed with Patient L.D. her pain medications and that the patient claimed her medications were being stolen and sold. Respondent stated that the patient was evaluated by a pain management specialist at UCSF for chronic pelvic pain; the patient received partial treatment for uterine carcinoma; that she complains of insomnia and claims Restoril is ineffective; that he prescribed Neurontin last fall in an attempt to lower her pain medications; and that he started the patient on Serzone in May for anxiety and panic attacks. Respondent's written medical records for patient L.D., however, do not adequately document this information.

ACTS OR OMISSIONS RE PATIENT L.D.

139. Respondent committed the following acts or omissions in the treatment of Patient L.D.:

A. Respondent failed to perform and/or document an adequate and complete medical and psycho-social history and/or physical examinations and/or diagnostic tests on patient L.D. including, but not limited to, a history of substance abuse and current

uses of drugs and alcohol and assessments of the patient's risk for substance abuse and addiction; and/or

B. Respondent failed to develop and/or document the development of a treatment plan with stated objectives and a periodic review and evaluation of the progress of his treatment plan; and/or

C. Respondent failed to adequately document a medical indication for the prescribing and use of controlled substances including, but not limited to, Temazepam, Xanax, and/or Vicodin; and/or

D. Respondent failed to adequately provide and/or document that patient L.D. was fully advised about her treatment and that she gave full informed consent regarding her treatment and medications; and/or

E. Respondent prescribed increased and/or excessive amounts of controlled substances, including tranquilizers, without adequately documenting or following standard prescribing guidelines, and/or without adequately documenting and/or performing proper monitoring, and/or without performing and/or documenting periodic review of the course of treatment; and/or

F. Respondent failed to keep adequate and/or accurate records regarding respondent's prescriptions and refills, including the type and the amounts, dispensed to patient L.D. and the patient's use of the prescribed dangerous drugs and controlled substances; and/or

G. Respondent repeatedly prescribed clearly excessive amounts of controlled substances, including tranquilizers and/or psychoactive drugs, without a medical indication therefor, and/or without a properly documented medical indication therefor; and/or

H. Respondent prescribed and refilled increased and/or excessive amounts of Vicodin and/or Xanax for patient L.D. without adequately performing and/or documenting an assessment of and treatment plan for management of the conditions for which they were prescribed, and/or without performing and/or documenting diagnostic

evaluations and/or trial of therapeutic alternatives and/or referral to a specialist and/or discussion of therapeutic alternatives with the patient; and/or

I. Respondent failed to adequately perform and/or document a regular monitoring and treatment of patient L.D.'s diabetic condition; and/or

J. Respondent failed to adequately perform and/or document a regular monitoring and treatment of patient L.D.'s hyperlipidemia; and/or

K. Respondent failed to adequately perform and/or document a substance abuse history and/or psycho-social history and/or risk of abuse assessment on patient L.D.; and/or

L. Respondent failed to adhere to the standard of practice by prescribing multiple drugs in combination which are known to have additive sedative and depressive effects, and/or prescribing drugs recommended for short-term therapy for an ongoing long-term basis without documenting a medical indication therefor; and/or

M. Respondent demonstrated a lack of knowledge and/or incompetence in improperly prescribing Temazepam for sleep disturbance on an ongoing basis without recognizing that it should be used for short-term therapy and the additive effects when combined with Xanax; and/or

N. Respondent failed to adequately perform and/or document a monitoring and/or treatment plan for L.D.'s diagnosis of uterine cancer; and/or

O. Respondent repeatedly failed to adequately respond and/or document a response to patient L.D.'s subjective complaints, including her complaints of chest pain, abdominal pain, loss of consciousness, concussion, and/or sexual assault), and failed to document a thorough medical history, examinations, and treatment plans and/or referrals; and/or

P. Respondent failed to timely recognize and/or treat and/or document the recognition and treatment of patient L.D.'s abuse of controlled substances and the patient's development of tolerance and addiction; and/or

Q. Respondent demonstrated a lack of knowledge and/or incompetence in the treatment of drug abuse and addiction, anxiety and depression, diabetes, hyperlipidemia, and obesity.

VIOLATIONS RE PATIENT L.D.

(Unprofessional Conduct/Gross Negligence/Incompetence)

140. Respondent's conduct with regard to patient L.D., as set forth in paragraphs 119 through 139 hereinabove, constitutes general unprofessional conduct and/or gross negligence and/or incompetence and is cause for disciplinary action pursuant to sections 2234, 2234(b), and/or 2234(d).

EIGHTEENTH CAUSE FOR DISCIPLINARY ACTION

(Re: Patient L.D.: Failure to Maintain Adequate Records)

141. Respondent's conduct as set forth in paragraphs 119 through 139 hereinabove constitutes unprofessional conduct in that he failed to maintain adequate and accurate records relating to the provision of services to L.D. and is cause for discipline pursuant to section 2266.

NINETEENTH CAUSE FOR DISCIPLINARY ACTION

(Re: Patient L.D.: Dishonest or Corrupt Acts re: Medical Records)

142. Respondent's conduct as set forth in paragraphs 119 through 139 hereinabove constitutes the commission of any act(s) involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon and is cause for disciplinary action pursuant to section 2234(e).

TWENTIETH CAUSE FOR DISCIPLINARY ACTION

(Re: Patient L.D.: Repeated Acts of Excessive Prescribing)

143. Respondent's conduct as set forth in paragraphs 119 through 139 hereinabove constitutes repeated acts of clearly excessive prescribing or administering of drugs or treatment or repeated acts of clearly excessive use of diagnostic or treatment

facilities as determined by the standard of the community of licensees and is cause for disciplinary action pursuant to section 725.

TWENTY-FIRST CAUSE FOR DISCIPLINARY ACTION

(Re: Patient L.D.: Prescribing to an Addict/Habitual User)

144. Respondent's conduct as set forth in paragraphs 119 through 139 hereinabove constitutes the prescribing or administering of drugs to an addict or habitual user and is cause for disciplinary action pursuant to section 2241 and to section 2238 in conjunction with section 11156 of the Health and Safety Code.

TWENTY-SECOND CAUSE FOR DISCIPLINARY ACTION

(Patient L.D.: Prescribing Without a Good Faith Exam and a Medical Indication)

145. Respondent's conduct as set forth in paragraphs 119 through 139 hereinabove constitutes the prescribing, dispensing, or furnishing of dangerous drugs without a good faith examination and medical indication therefor and is cause for disciplinary action pursuant to section 2242(a).

TWENTY-THIRD CAUSE FOR DISCIPLINARY ACTION

(Patient L.D.: Excessively Prescribing Controlled Substances)

146. Respondent's conduct as set forth in paragraphs 119 through 139 hereinabove constitutes the prescribing of controlled substances in excess of such quantity and length of time as is reasonably necessary and is cause for disciplinary action pursuant to section 2238 in conjunction with section 11210 of the Health and Safety Code.

TWENTY-FOURTH CAUSE FOR DISCIPLINARY ACTION

(Patient L.D.: Prescribing Without a Legitimate Medical Purpose)

147. Respondent's conduct as set forth in paragraphs 119 through 139 hereinabove constitutes prescribing, dispensing, or furnishing controlled substances without a legitimate medical purpose and therefore is cause for disciplinary action pursuant to section 2238 in conjunction with section 11153(a) of the Health and Safety Code.

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TWENTY-FIFTH CAUSE FOR DISCIPLINARY ACTION

(Patients A.R., L.S. and L.D.: Repeated Negligent Acts)

148. Respondent is subject to disciplinary action under section 2234(c) of the Business and Professions Code in that respondent engaged in repeated negligent acts a conduct with regard to his treatment of patients A.R., L.S. and L.D.. The circumstances are as alleged in the First Cause for Disciplinary Action paragraphs 31 through 45, the Ninth Cause for Disciplinary Action paragraphs 56 through 108, and the Seventeenth Cause for Disciplinary Action paragraphs 119 through 139, which are incorporated herein as though fully set forth.

PRAYER

WHEREFORE, the complainant requests that a hearing be held on the matters herein alleged and that following the hearing the Division issue a decision and order:

1. Revoking or suspending Physician and Surgeon Certificate number G 46239, issued to respondent William H. Johnson, Jr., M.D.;

2. Prohibiting respondent William H. Johnson, Jr., M.D., from supervising a Physician Assistant;

3. Ordering respondent William H. Johnson, Jr., M.D., to pay the Division the reasonable costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring.

4. Taking such other and further action as may be deemed just, proper and appropriate.

DATED: April 12, 1999

RONALD JOSEPH
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California

Complainant